

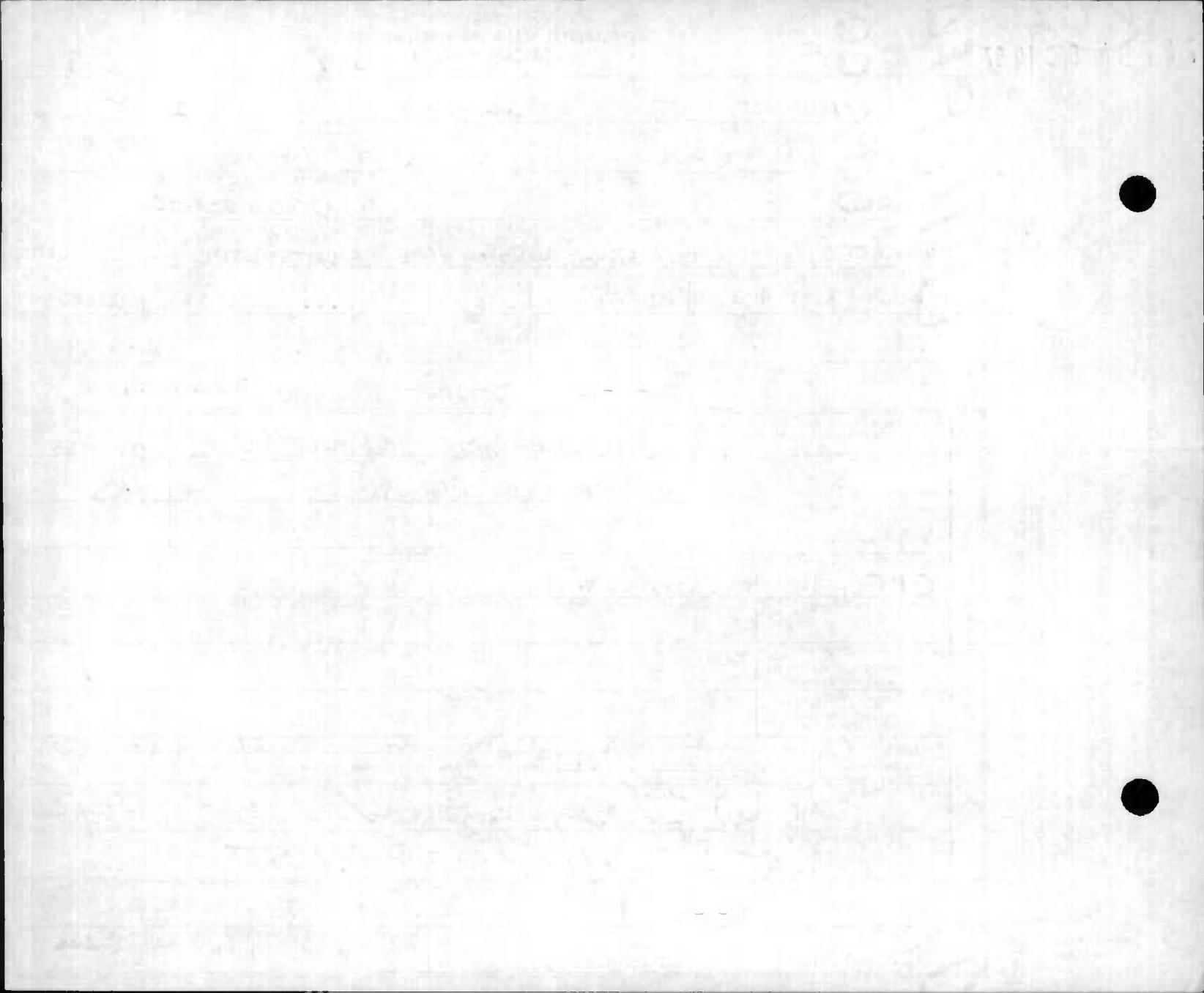
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by you in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as item 18 shows only injury, or other traumatic event, the medical certification section must be filled in.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1 - FOR STATE REGISTRAR			87 REG. NO. 35625										
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR	
ALBERT T ALLISON						12 2 87						2:25 PM	
3 SEX <i>m</i>		4 RACE <i>CAUC</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 22 88</i>			6 AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>CANADA</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i>						
10 CITY OR TOWN OF DEATH <i>Williamsburg</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>St. Mary's Nursing Home</i>						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SHEET METAL</i>			12b KIND OF BUSINESS OR INDUSTRY <i>Manufacturing</i>	
13a STATE <i>Maryland</i>			13b COUNTY <i>Caroline</i>		13c CITY OR TOWN <i>Henderson</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS P.O. Box 4			21640	
14 FATHER'S NAME FIRST <i>Thomas</i>			MIDDLE <i>M.</i>		15 MOTHER'S MAIDEN NAME FIRST <i>Regina</i>		MIDDLE <i>M.</i>			LAST <i>Poirier</i>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b SOCIAL SECURITY NO. <i>024-24-3319</i>			17 INFORMANT <i>Donald Allison</i>			ADDRESS <i>Henderson, MD</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>myocardial infarction</i>													
DUE TO, OR AS A CONSEQUENCE OF (b): <i>generalized ASCVD</i>												<i>YRS</i>	
DUE TO, OR AS A CONSEQUENCE OF (c):													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>CHF, intraventricular thrombus</i>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN COUNTY STATE				
22a I certify that <input checked="" type="checkbox"/> (I) this hospital attended the deceased from <i>8/24/87</i> to <i>12/1/87</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>8/24/87</i> , and that in my <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) we did not view the body after death.												22c. DATE SIGNED <i>12/2/87</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>HUBERT L. FEARY</i>			22e ADDRESS <i>503 BYRN ST</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-4-87</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Cross Cem.</i>			23d. LOCATION CITY OR TOWN <i>Dover</i>			COUNTY STATE <i>Kent DE</i>	
24 FUNERAL DIRECTOR NAME <i>John E. Boulais</i>			ADDRESS <i>Greensboro, MD</i>			24e RECEIVED BY REGISTRAR <i>DEC 10 1987</i>			24f. REGISTRAR'S SIGNATURE <i>Julia Sanderson-Boulais</i>				



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS 201 WENSTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 G N 5 2 6

DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE KNOWN OF DEATH ESTIMATED	XX MONTH DAY YEAR	2b. HOUR	
John William Benjamin					<input checked="" type="checkbox"/> 11-28 1987		24 HOUR	
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	24 HOUR	
Male	White	June 25, 1930	57		<input type="checkbox"/> 11-28 1987		8:10 p.m.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		
Iowa		U.S.A.				Dorchester County, MD		
CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge		Dorchester General Hospital		Engineer		Poultry 99999		
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
14a STATE	14b COUNTY	14c CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS	13f ADDRESS			
Pennsylvania	Lancaster	Lancaster	<input checked="" type="checkbox"/>	973 Nissley Rd. 17601	Lancaster, PA 17601			
FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST	
Herbert			Benjamin	Virgil			Huff	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		482-34-2687		Patricia A. Benjamin, 973 Nissley Rd.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease								
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b) _____ DUE TO, OR AS A CONSEQUENCE OF								
(c) _____								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Margarita A. Korell, M.D. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-29-87								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec. 2, 1987		23c. NAME OF CEMETERY OR CREMATORY St. Joseph's		23d. LOCATION CITY OR TOWN Lancaster, Lancaster, PA		COUNTY STATE
Burial		Dec. 2, 1987		St. Joseph's		Lancaster, Lancaster, PA		
24. FUNERAL DIRECTOR		25a. DATE RECD. BY REGISTRAR DEC 01 1987		25b. REGISTRAR'S SIGNATURE				
ROBERT C. ALtenburg FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, Md. 21214								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon paper, page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event,

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8735627					
1 - STATE REGISTRAR			FIRSt			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
T DECEASED NAME (TYPE OR PRINT)			Leon			Dale			Bradley			December 30, 1987					M
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR			8 IF UNDER 24 HRS					
Male		White		Month Day Year October 30, 1895			92 YRS		MONTHS DAYS			HOURS MIN.					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY										
Federalburg		Rt 1 Box 33 (At Home)		Farmer													
13a STATE		13b COUNTY		13c CITY OR TOWN			13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE								
Maryland		Dorchester		Federalsburg			No <input checked="" type="checkbox"/>		Rt 1 Box 33 21632								
14. FATHER'S NAME		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME										
Zacchaeus		Dale		Bradley			Sophia		Pattison								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			ADDRESS										
No		216-56-0972		Mary Ellen Bradley Item # 13													
18 CAUSE OF DEATH (Enter only one cause per line for item 18, and item 19c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>												Minutes					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <i>ASCO &amp; Anginal Syndromes</i>																	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>FRS</i>																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1c																	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1c OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED  WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY			STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>12/24/87</i> , to <i>12/30/87</i> , that (I) (we) last saw the deceased alive on <i>12/14/87</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												22c DATE SIGNED <i>1/4/88</i>					
22b. SIGNATURE <i>Donald T. Lewers M.D.</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DONALD T. LEWERS M.D.</i>			22e DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial 1/2/88</i>		23c. NAME OF CEMETERY OR CREMATORIAL Unity Wash Cem			23d. LOCATION CITY OR TOWN <i>Hurlock</i>		COUNTY			STATE					
24 FUNERAL DIRECTOR NAME <i>THOMAS FUNERAL HOME CAMBRIDGE, MD.</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR <i>JAN 11 1988</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Smith</i>										

EX-100



**TO HOSPITAL OR ATTENDING PHYSICIAN.** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be renewed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and certified in the usual manner, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 will be retained by the funeral director. Page 3

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MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR
MARY Jane CANNON			11 12 87	12:30 PM	
9-67 SEX Female		4. RACE White	5. DATE OF BIRTH MONTH 12 DAY 31 YEAR 18	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co., MD.	
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Beautician	
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 801 Radiance Drive 21613
14. FATHER'S NAME FIRST MIDDLE LAST George Dewey Anderson		15. MOTHER'S MAIDEN NAME Agnes L. Webster			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 123-18-5969		17. INFORMANT George E. Cannon, Jr. Item # 13	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH z 40 min					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) HOSP					
19a. DATE OF OPERATION 10/21/87		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Right Total hip		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 10/20/87 to 11/12/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.					
22b. SIGNATURE Hubert L Ferry		DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 11/12/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L Ferry		22e. ADDRESS 503 Bayview St			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 11/14/87	23c. NAME OF CEMETERY OR CREMATORIAL E. New Mkt Cem.	23d. LOCATION CITY OR TOWN E. New Market Dor. Md.	STATE
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME CAMBRIDGE, MD.		25. DATE REC'D. BY REGISTRAR NOV 18 1987		25b. REPORTER'S SIGNATURE Julia [Signature]	
ADDRESS					

SEARCHED

6

NOV 18 1981 VON

BP \_\_\_\_\_  
 DHMH - 16 60M 7/84  
 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon stamp. Please do not sign until you have checked with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 37 355629	
DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
JAMES			W				CEPHAS SR.		DEC. 2 1987				9:15 PM
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7 IF UNDER 1 YEAR		8 IF UNDER 72 HRS			
Male		Black		Month Day Year Aug 16 21		66 YRS		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Md.		U.S.A.				Dorchester		Cambridge		Dorchester Gen Hosp.		Retired	
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE		12b KIND OF BUSINESS OR INDUSTRY			
Md.		Dorchester		Cambridge		YES <input checked="" type="checkbox"/>		RTI Box 115 Vienna Md. 21867		Retired			
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME		ADDRESS		LAST			
Charles		W		Cephas		Sarah		L		Thompson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO.		17. INFORMANT		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
				215-26-5263		France A. Cephas		18 DAYS					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEFT CEREBRAL INFARCTION													
DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c) HYPERTENSION													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CORONARY ARTERY DISEASE													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTED, MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 12/2 1987									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOWHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE					
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on 12/2 1987, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) did not view the body after death.													
22b. SIGNATURE Michael A. Mockewicz MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-2-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL A. MOCKEWICZ MD		22e. ADDRESS 503 BRYAN ST. CAMBRIDGE MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/87		23c. NAME OF CEMETERY OR CREMATORIAL Water's Church Cemetery		23d. LOCATION Fork Neck Dor. md.							
24. FUNERAL DIRECTOR NAME Stewart Funeral Home		ADDRESS Cambridge Md.		25a. DATE REC'D. BY REGISTRAR DEC 03 1987		25b. REGISTRAR'S SIGNATURE Julia Sanderson-Radcliffe							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be submitted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon copy, sign and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

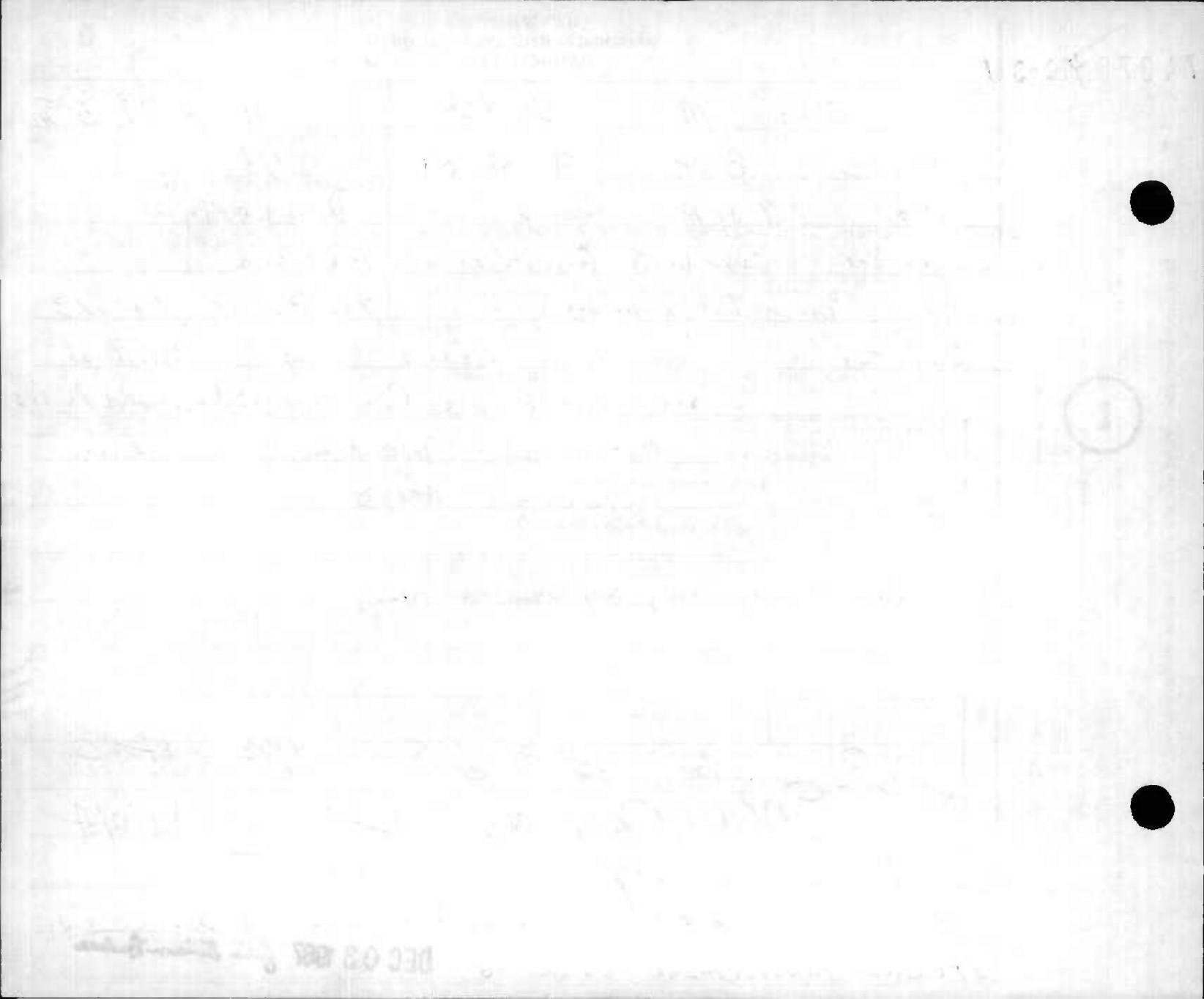
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 35630

1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Elsie</i>	MIDDLE <i>M</i>	LAST <i>CORNISH</i>	2a DATE OF DEATH MONTH <i>9</i>	MONTH <i>08</i>	DAY <i>09</i>	YEAR <i>87</i>	2b HOUR <i>5:25 AM</i>		
3. SEX <i>Female</i>		4 RACE <i>Black</i>	5 DATE OF BIRTH MONTH <i>9</i>	DAY <i>08</i>	YEAR <i>09</i>	6 AGE (IN YEARS LAST BIRTHDAY) 78 yrs.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. DAYS <i>0</i>	2b HOUR HOURS <i>5</i>	MIN. <i>25</i>			
7a. BIRTHPLACE COUNTRY <i>Md.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i>						
10 CITY OR TOWN OF DEATH <i>Cambridge</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester Gen Hospital</i>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>		12b KIND OF BUSINESS OR INDUSTRY						
13a STATE <i>Md.</i>		13b COUNTY <i>Dorchester</i>	13c CITY OR TOWN <i>Cambridge</i>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>1942 Pine St / 21613</i>							
14. FATHER'S NAME FIRST <i>Augustus</i>		MIDDLE <i></i>	LAST <i>Enwells</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Bessie</i>		MIDDLE <i>W</i>	LAST <i>Phillips</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. <i>214-07-8618</i>			17 INFORMANT <i>Frances Cornish</i>	ADDRESS <i>1005 Jimpson Rd / 21613</i>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized ASCVD</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>Class IV heart failure, Sick Senu's syndrome</i>													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH [IF EITHER, NOTIFY MEDICAL EXAMINER]		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE			
22a I certify that (I) this hospital attended the deceased from <i>10/20</i> , 19 <i>59</i> , to <i>14/12</i> , 19 <i>87</i> , that (I) we lost saw the deceased alive on <i>10/24</i> , 19 <i>87</i> , and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.												22c DATE SIGNED <i>14/12/87</i>	
22b SIGNATURE <i>Hubert L. Peay</i>		22c DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>				
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Hubert L. Peay</i>		22e ADDRESS <i>503 Bypn St</i>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>11/18/87</i>		23c NAME OF CEMETERY OR CREMATORIAL <i>Sohne Wesley Cen</i>		23d LOCATION CITY OR TOWN <i>Lions Rd Dor. Md.</i>		COUNTY		STATE			
24 FUNERAL DIRECTOR NAME <i>Stewart Funeral Home</i>		ADDRESS <i>Camb. Md.</i>			25a DATE REC'D. BY REGISTRAR <i>DEC 03 1987</i>		REGISTRAR'S SIGNATURE <i>Jane Johnson-Buchanan</i>						



076544 DEC 30 87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed, let the certifying physician (and completely filled in by the funeral director, page 2) should be detached for use in the burial permit. Then attach remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 23 is checked or Item 18 shows any injury, either traumatic or non-traumatic, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 07 35631												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	
<i>Mollie</i>			<i>J.</i>	<i>Custis</i>		12-24-87					2b. HOUR 1 P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
female		white		Month June Day 26 Year 1894			93 YRS		MONTHS - DAYS		HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD				
Virginia		U.S.A.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Ambridge		520 Glenburn Ave.			sewing machine operator							
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 520 Glenburn Ave. 21613				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST			
Thomas				Chandler	Alice				Hicks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT		ADDRESS 205 Buena Vista Ave. Cambridge Md.					
NO		220-26-3554			Wm. T. Custis							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardio-Respir. Arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Smile m/</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>AS CVD</i>												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>Oxygen B. Syndrome</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>G. Cannon</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL DOR. MEM. PARK			23d. LOCATION CITY OR TOWN CAMBRIDGE DOR. D. M. D.		23e. COUNTY BALTIMORE		23f. STATE	
burial		12/27/87										
24. FUNERAL DIRECTOR NAME <i>Thomas Funeral Home</i>		ADDRESS			25a. DATE REC'D. BY REG. TRA. 25b. REGISTRATION SIGNATURE DEC 29 1987							
BP												
DHMH - 16 60M 7/84 (VRA 15, 4)												

WCCB 143010

DEC 30 1981

77087 JAN -5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 45632

FOR  
STATE  
REGISTRAR

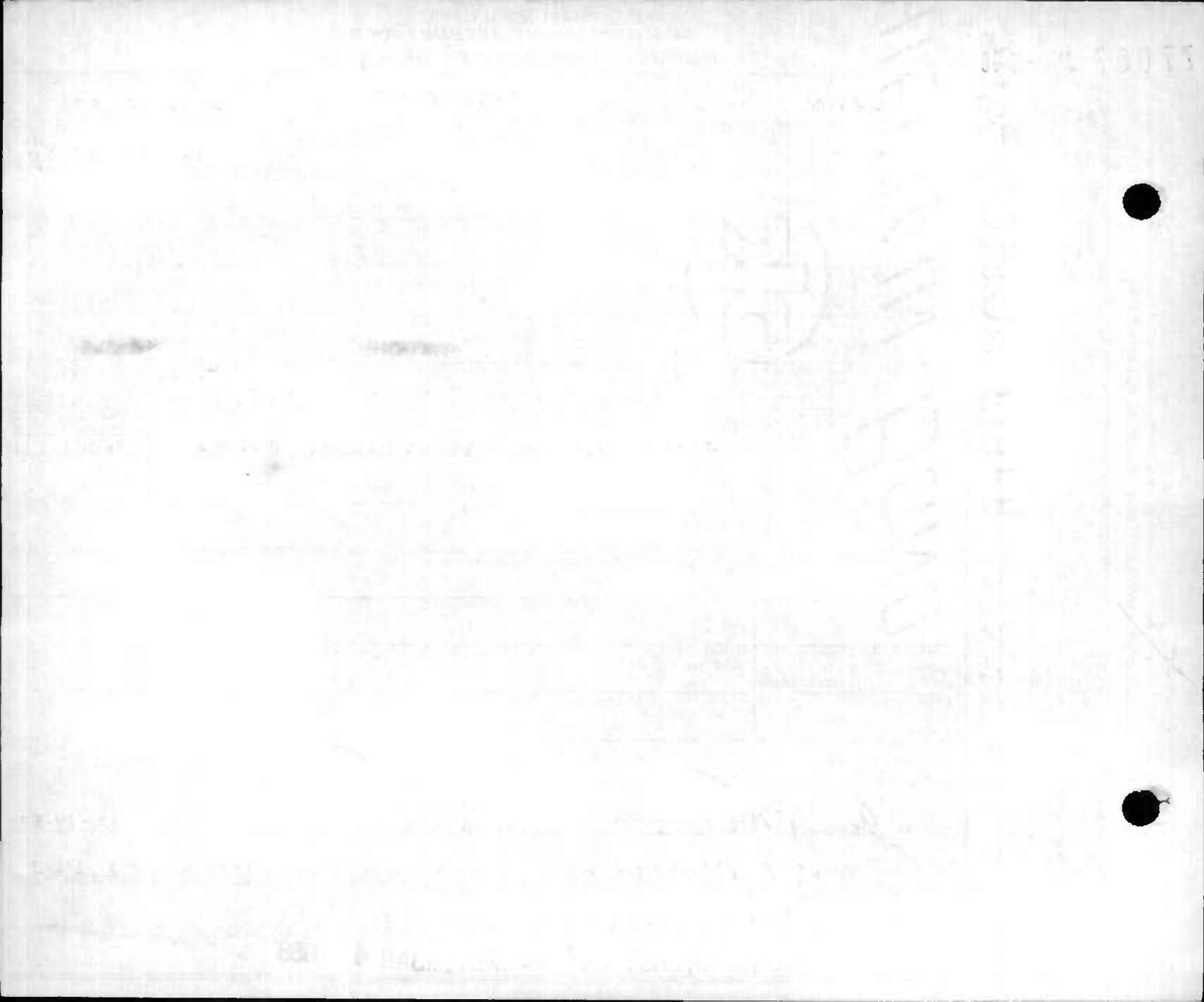
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 14. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>LEVIN</i>	MIDDLE <i>S</i>	LAST <i>DAVENPORT</i>	2a. DATE KNOWN OF ESTI- MATED	MONTH 12	DAY 12	YEAR 1987	2b. HOUR M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH 6	DAY 24	YEAR 14	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN:	
MALE	WHITE									
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		2c. DATE PRONOUNCED DEAD
MARYLAND		USA				<input checked="" type="checkbox"/>		<input type="checkbox"/>		12 13 1987
8p M										
10. CITY OR TOWN OF DEATH <i>VIENNA</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>ELLIOTT ISLAND ROAD</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>FARMER</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>FOREST</i>
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>DORCHESTER</i>		13c. CITY OR TOWN <i>VIENNA</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>ELLIOTT ISLAND ROAD/21869</i>		
14. FATHER'S NAME FIRST <i>JOSEPH</i>		MIDDLE -	LAST <i>DAVENPORT</i>		15. MOTHER'S MAIDEN NAME FIRST <i>MATTIE</i>		MIDDLE E.	LAST <i>WILLEY</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. - - - - -		16c. ADDRESS <i>P. O. BOX 113</i>		17. INFORMANT <i>ROSCOE DAVENPORT, FRANKFORD, DE</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>YEARS</i>
Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
TITLE (SPECIFY) <i>JAMES F. McCARTER, M.D.</i>										
EXAMINER'S NAME (TYPE OR PRINT)		M.D.		DEPUTY		MEDICAL EXAMINER				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>12-16-87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>ST. PAUL'S CEMETERY</i>		23d. LOCATION CITY OR TOWN <i>VIENNA, DORCHESTER, MD</i>		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME <i>ZELLER FUNERAL HOME, EAST NEW MARKET</i>		ADDRESS <i>MDA N 4</i>		25a. DATE REC'D. BY REGISTRAR <i>1988</i>		25b. REGISTRAR'S SIGNATURE <i>✓</i>				
DHMH - 17 (VR A15 ME (5)) 15M 2/80										







STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35634  
REG. NO.

73479 DEC -

FOR  
STATE  
REGISTRAR  
87

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL. PAGE 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1A, 2, AND 3. PAGE 3 SHOULD BE USED AS A BURIAL TRUST STATEMENT. PAGES 1A, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)		FIRST <b>LOUIS</b>	MIDDLE <b>FULTON</b>	LAST <b>FISHER</b>	2a. DATE KNOWN OF DEATH ESTIMATED MATED	MONTH 11/26/87	DAY 19	YEAR 87	2b. HOUR ? M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 79 yrs.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.			
Male	White	Oct 5, 1908									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		9. DATE PRONOUNCED DEAD			10. BALTIMORE CITY OR COUNTY OF DEATH		
<b>Maryland</b>		<b>US</b>		<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED		<b>11-26-87</b>			<b>Dorchester Co.</b>		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
<b>Elliott</b>		<b>At Home</b>				<b>Unemployed</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Dorchester</b>		13c. CITY OR TOWN <b>Elliott</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>N/A</b>			
14. FATHER'S NAME FIRST <b>John</b>		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST <b>Angirona</b>		MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT		ADDRESS <b>609 Smith St. #1 Salisbury, Md.</b>			
Yes				214-46-4914		Margaret Wallace					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>James F. McCarter</i>		M.D. <b>DEPUTY</b> MEDICAL EXAMINER						DATE SIGNED <b>11-27-87</b>			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS <b>42 AURORA ST. CAMBRIDGE, MD. 21613</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <b>Burial 11/29/87</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>St. Paul's Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Vienna Dor. Md.</b>		COUNTY STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS <b>THOMAS FUNERAL HOME CAMBRIDGE, MD.</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 30 1987</b>		25b. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i>	

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

11-33-2546X

11-33-2546X

11-33-2546X

077062 JAN

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE	LAST	Faine	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Troy		Troy	Faine	Faine	12	28	87		11.15 P.M.	
3. SEX		RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		Cauc.	MONTH	DAY	YEAR	82	YEARS	MONTHS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.
West Virginia		U.S.A.				Dorchester				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge		Dorchester General Hospital		Carpenter		Contractor				
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 903 Springfield Ave. 21613				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		Nancy	MIDDLE	Jane	LAST	Jones
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS				
No		235-30-9150		(wife) Mrs. Marie Faine, same as #13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										
DUE TO, OR AS A CONSEQUENCE OF (b)										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
DUE TO, OR AS A CONSEQUENCE OF (c)										
ASCVD & A.Fib.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>E. Tanman</i>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-28-67				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman		22e. ADDRESS 17 Franklin St., Cambridge, MD. 21613								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-31-87		23c. NAME OF CEMETERY OR CREMATORIAL Harford Mem. Gardens		23d. LOCATION CITY OR TOWN Harford, MD		23e. COUNTY STATE		
24. FUNERAL DIRECTOR NAME Curran Funeral Home 308 High St., Cambridge, MD. 21613						25a. DATE REC'D. BY REGISTRAR JAN 4 1988		25b. REGISTRAR'S SIGNATURE <i>Joe Curran</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. If 2 copies are used, keep 1 copy within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

INDICANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

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000-10000

073790 DEC 3-87  
Page 4 may be  
referred to in the full certificate, page 3  
should be detached for use as the burial-transit permit. Then please remove carbon paper. Please  
return by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Please return by the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 35396
1. DECEASED NAME (TYPE OR PRINT)			FIRST JOHN	MIDDLE DELZELL	LAST GARST, SR.		2a. DATE OF DEATH NOVEMBER 12, 1987	MONTH YEAR 11:20 P M	2b. HOUR	
3. SEX MALE			4. RACE WHITE		5. DATE OF BIRTH MONTH MAY DAY 2 YEAR 1902		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSOURI			7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER COUNTY		MD.	
10. CITY OR TOWN OF DEATH EAST NEW MARKET			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GREEN POINT ROAD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) EXECUTIVE		12b. KIND OF BUSINESS OR INDUSTRY OIL INDUSTRY			
13a. STATE MARYLAND			13b. COUNTY DORCHESTER		13c. CITY OR TOWN EAST NEW MARKET		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE GREEN POINT ROAD/21631	
14. FATHER'S NAME FIRST JOHN			MIDDLE BARTON	LAST GARST	15. MOTHER'S MAIDEN NAME FIRST DAISY		MIDDLE	LAST DELZELL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 077-24-9785		17. INFORMANT MARIETTA D. GARST, EAST NEW MARKET, MD 21631		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for item (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Esophageal Cancer</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>year</i>
DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>August 27</i> , 1987, to <i>11/20</i> , 1987, that (I) (we) last saw the deceased alive on <i>11/9</i> , 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <i>11/27/87</i>
22b. SIGNATURE <i>H.E. Aycliffe</i>			22d. PHYSICIAN'S NAME (TYPE) <i>H.E. Aycliffe</i>		22e. DEGREE <i>MD</i>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 11-17-87		23c. NAME OF CEMETERY OR CREMATORIAL OLD TRINITY CHURCHYARD		23d. LOCATION CITY OR TOWN CHURCH CREEK, DORCHESTER, MD			
24. FUNERAL DIRECTOR NAME ZELLER FUNERAL HOME, EAST NEW MARKET, MD			25a. DATE REC'D. BY REGISTRAR DEC 02 1987		25b. REGISTRAR'S SIGNATURE <i>Jeanne Deidra Rundall</i>					

100 200 300



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGE 4 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 35837								
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF DEATH ESTIMATED			2b. MONTH YEAR	2b. DAY YEAR	2b. HOUR M			
Sigmund C. Hartman												<input checked="" type="checkbox"/> 12 5 1987			12 5 1987		12 5 1987			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) YRS.			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. MONTH YEAR		2e. HOUR M	
M		White		7 14 20			67							12 5 1987			12 5 1987		13 30 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. DATE OF BIRTH MONTH DAY YEAR			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH										
New York		U.S.A.		7 14 20			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Dorchester MD.										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Route 16										Retired			Sales					
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS					
14. STATE Maryland		14b. COUNTY Howard		14c. CITY OR TOWN Ellicott City						9078 A Town & Country Blvd.			21043							
14d. FATHER'S NAME FIRST		14e. MIDDLE		14f. LAST			15. MOTHER'S MAIDEN NAME FIRST													
Joel Sigmund Hartman							May Wienstien													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
Yes		WWII		044 12 5329A			M's Alma Hartman			9078 A Town & Country Blvd										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8129												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0								
IMMEDIATE CAUSE (a) <b>Hemo pericardium</b> DUE TO, OR AS A CONSEQUENCE OF																				
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																				
(b) <b>Laceration of Rx. ventricle</b> DUE TO, OR AS A CONSEQUENCE OF																				
(c) <b>of heart</b>																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> AM MONTH DAY YEAR P.M. 12-5 1987			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART I OR PART 2)			21d. LOCATION STREET			CITY TOWN COUNTY STATE									
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rx. 76																		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Peter W. Rieckert		TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 14-5-87								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS										E. New Market Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY TOWN			COUNTY STATE									
Cremation		Dec. 7, 1987			Westview Memorial Park			Catonsville Balt. Md.												
24. FUNERAL DIRECTOR NAME		ADDRESS			City			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Harry H Witzke 4112 Old Columbia Pike Ellicott								DEC - 7 1987			John W. Rieckert									
BP																				
DHMH - 17 (VR A15 ME (5)) 15M 2/80																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8735638						
1 - STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			5. DATE OF BIRTH			MONTH DAY		YEAR		6. AGE IN YEARS LAST BIRTHDAY			
James M. Haward						10 10 92			95				IF UNDER 1 YEAR MONTHS DAYS			
3. SEX			4. RACE			7. DATE OF BIRTH			YEAR		IF UNDER 24 HRS MONTHS DAYS		11:00PM			
Male			BLK			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			95		YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
MD			USA			Crambliss House Home			Dorchester MD.			Self-employed				
10. CITY OR TOWN OF DEATH			NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			11a. USUAL RESIDENCE IF DIFFERENT FROM PLACE OF DEATH (HOME OR OTHER INSTITUTION. GIVE RESIDENCE BEFORE ADMISSION)			11b. COUNTY			13c. CITY OR TOWN			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Cambridge			Crambliss House Home			MD			Talbot			Trappe			Self-employed	
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
James			Haward			Legal										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			218-24-2636			Constance H. Frisby									4 years	
18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			CONGESTIVE HEART FAILURE			DO TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROSIS									4 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DO TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART II)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/3 1986, to 12-18 1987, that (I) (we) lost saw the deceased alive on 12-18 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death														22c. DATE SIGNED 12-18-87		
22b. SIGNATURE Michael A. Moskewicz			DEGREE MA			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-18-87							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 503 Bryn St. CAMBRIDGE MD												22c. DATE SIGNED 12-18-87	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/23/87			23c. NAME OF CEMETERY OR CREMATORIAL Oxford Neck Cemetery			23d. LOCATION TOWNSHIP Oxford TA COUNTY MD							
24. FUNERAL DIRECTOR Dorothy L. Dorsey			ADDRESS 315 Main St. Boston Md.			25. DATE REC'D. BY REGISTRAR DEC 23 1987										

BP \_\_\_\_\_

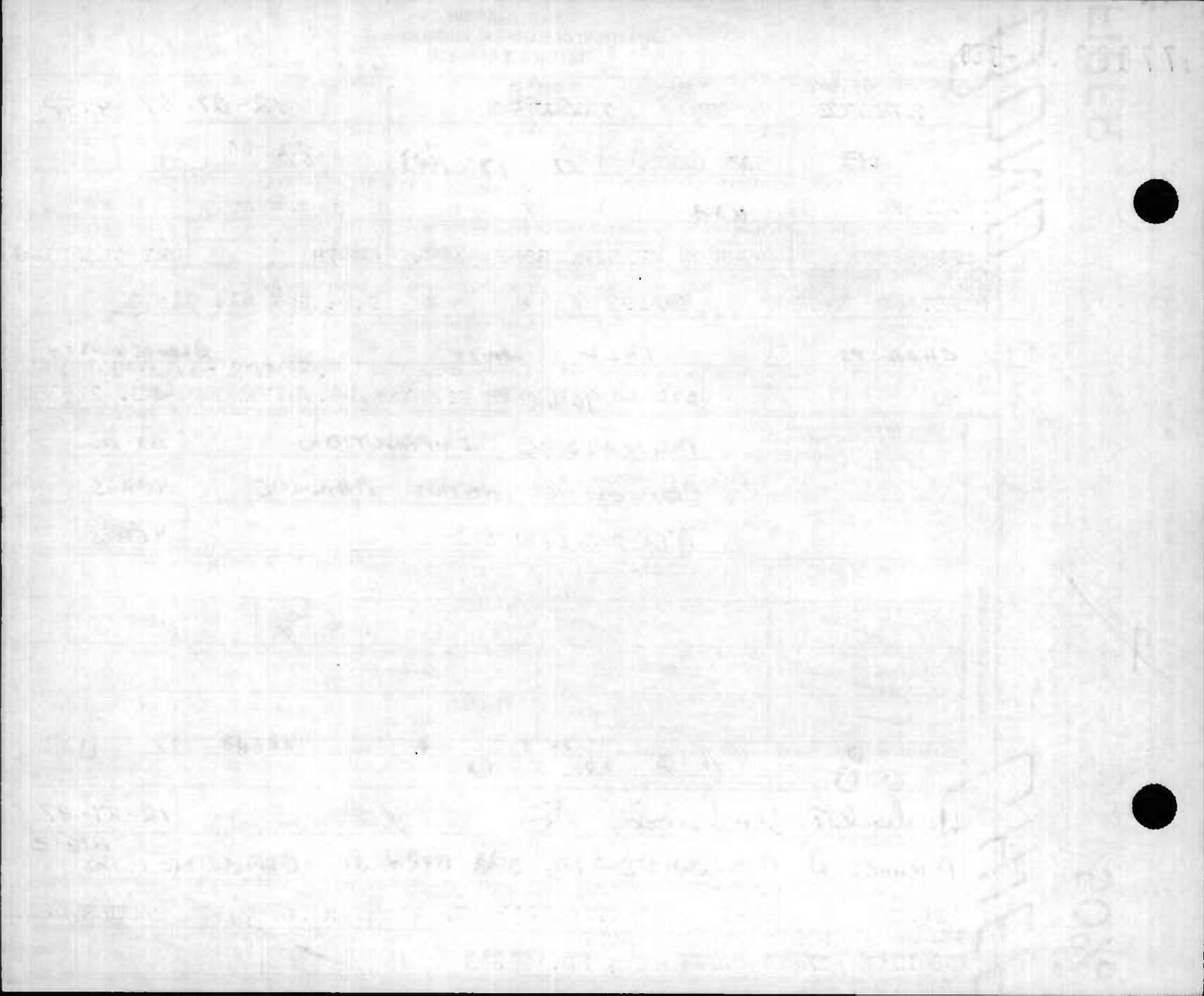
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH															
377063 JAN - 5 68 STATE REGISTRAR											REG. NO. 87 35639				
1. DECEASED NAME (TYPE OR PRINT) <b>NAOMI XXXXXXXX</b>			MIDDLE <b>MAY XXI</b>	LEWIS <b>XXXXXXX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>12-27-87</b>			2b. HOUR <b>9:15 P.M.</b>					
3. SEX <b>FEMALE XX</b>		4. RACE <b>XXX CAUC.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 17 1903</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>XXXX 84 YRS</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>DORCHESTER</b>								
10. CITY OR TOWN OF DEATH <b>CAMBRIDGE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>GLASGOW NURSING HOME, INC.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>OWNER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>DRY CLEANING</b>			MD.					
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>TRAPPE</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>P.O. BOX 61, 21673</b>						
14. FATHER'S NAME FIRST <b>CHARLES</b>		MIDDLE <b>F.</b>	LAST <b>TALL</b>	15. MOTHER'S MAIDEN NAME FIRST <b>LENISE</b>			MIDDLE		LAST <b>BLOODSWORTH</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>222-20-9636</b>		17. INFORMANT NEPHEW, P.O. BOX 63, LINKWOOD PETE ROBBINS, DR., LINKWOOD, MD. 21835											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> (c) <u>ATHEROSCLEROSIS</u>												<b>4 years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.												<b>4 years</b>			
19a. DATE OF OPERATION <u>/</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>/</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (his hospital) attended the deceased from <u>1-7</u> , 19 <u>81</u> , to <u>12-27</u> , 19 <u>87</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>11-3 1987</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE <u>Naomi A. Moskewicz</u>		22c. DEGREE <u>MA</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <b>12-27-87</b>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Moskewicz</u>		22e. ADDRESS <b>503 BURN ST. CAMBRIDGE MD 21613</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>12-30-1987</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>GRACELAWN MEM PK WILMINGTON, NEW CASTLE, DEL.</b>			23d. LOCATION CITY OR TOWN <b>WILMINGTON, NEW CASTLE, DEL.</b>								
24 FUNERAL DIRECTOR NAME <b>CURRAN FUNERAL HOME 308 HIGH STREET, CAMBRIDGE, MD. 21613</b>		25a. DATE REC'D. BY REGISTRAR <b>JAN 4 1988</b>		25b. REGISTRAR'S SIGNATURE <u>John J. Curran Jr.</u>											
TO HOSPITAL OR ATTENDING PHYSICIAN: This now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.															
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use on the burial/tranier permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene under Funeral Removal.															
IMPORTANT: If item 21 is marked as Item 18 shows any injury, or other trauma, in event of a medical examination, the medical examiner															
BP _____															

DHMH - 16 50M 4/83  
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 67 35640											
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2d. HOUR											
Melinda Lynn Marine						11	17	87				10:20 P.M.											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS											
Female		White		MONTH	DAY	YEAR	16			MONTHS	DAYS	HOURS	MIN.										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.													
Md.		USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY															
Cambridge		Dorchester General Hospital			Student																		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21643											
Md.		Dor.		Hurlock		P. O. Box 1026 Hurlock, Md.																	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME																		
		Otis	Harry	Marine	Phyllis																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS															
No					Phyllis Marine Item # 13																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												REPRODUCTIVE arrest											
(b) DUE TO, OR IS A CONSEQUENCE OF Reproduction, acute																							
(c) DUE TO, OR IS A CONSEQUENCE OF Pontine brain abscess																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral - peritoneal shunt																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?															
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE									
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____. that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22b. SIGNATURE REINHARDT SAMUEL MD DEGREE PATHOLOGIST								22c. DATE SIGNED 11/19/87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																					
Reinhardt Samuel MD LAB, Dorchester Gen. Hospital																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			CITY OR TOWN			COUNTY			STATE							
Burial		11/21/87		Bucktown Church			Cambridge Dor			Cambridge Dor			Md.										
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REG. OFFICER			25b. REGISTRAR'S SIGNATURE															
THOMAS FUNERAL HOME CAMBRIDGE, MD.					NOV 24 1987			Julia Sanderson-Lindner															

WZ 000010610

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

35941  
REG. NO.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. AN ANNOTATION SHOULD BE MADE IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 4 AND 5 SHOULD BE TITLED "WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL."

## MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	20. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR	24 HOUR	
PAMELA L. MEERKINS							<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	11	26	1987	12 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	21. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	24 HOUR		
Female	Black	10 4 58	29 yrs.			<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	19			M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		U.S.A.			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Dorchester Co. MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Cambridge		Dorchester Gen Hospital												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 635 High St. / 21613						
Md.		Dorchester		Cambridge		YES <input checked="" type="checkbox"/>								
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		Chester						
Robert				Camper		Reginia								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT		ADDRESS							
(YES, NO, OR UNKNOWN)		214-10-5606			Randolph Meerkins									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
{ (b) CARDIAC VENTRICULAR FIBRILLATION DUE TO, OR AS A CONSEQUENCE OF												MINUTES		
{ (c) CARDIAC SARCOIDSIS												YEARS		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
					<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY)		
ACTUAL SIGNATURE <i>Jeanne F. Meekins</i>												M.D. DEPUTY MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE			
Burial		12/3/87		Union Chapel Ceme.			Condover		Dorchester		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Stewart Funeral Home		Cambridge, Md.		DEC 03 1987			<i>Julia Sanderson-Randall</i>							

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

100-000250 AT

100-000250

074891 DEC 11 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8135642

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
LILBURN TROY MILLER						12	887		324 AM	
3 SEX		4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
M		W	MONTH	DAY	YEAR	67			MONTHS	DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8, BALTIMORE CITY OR COUNTY OF DEATH		
WICHITA		US						BOSTON		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
CAMBRIDGE		ESHC						MOM		
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS		
MD		WIC		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		JOHNSON Rd RT 4 21801		
14 FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		16 ADDRESS			
MARSHALL				MILLER	Dorothy		Miller			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO			17 INFORMANT		18 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
NO		226-29-9244			MEDICAL RECORDS ESHC		minutes			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CARDIO - PULMONARY ARREST</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION 0		19b CONDITION FOR WHICH OPERATION WAS PERFORMED D			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____					
22a I certify that (I) (this hospital) attended the deceased from the deceased died on 12/11/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <u>George H. Bush</u>		DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c DATE SIGNED 12/8/87			
22d PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE H. BUSH MD		22e ADDRESS EAST 54 10TH ST. WATER CAMBRIDGE, MD 21613								
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b DATE 12/11/1987		23c NAME OF CEMETERY OR CREMATORIAL Spring Hill Mem. Ma		23d LOCATION CITY OR TOWN Hebron, WICOMICO MD		23e COUNTY STATE		
24 FUNERAL DIRECTOR NAME BAKER & BOUNDS SALISBURY, MD 21801		ADDRESS			25a DATE REC'D. BY REGISTRAR DEC 11 1987		25b. REGISTRAR'S SIGNATURE Julia Darden-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed (see page 1), it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the means of protection must be shown on page 4.

70 M 022-100-150

DEC 11 1985

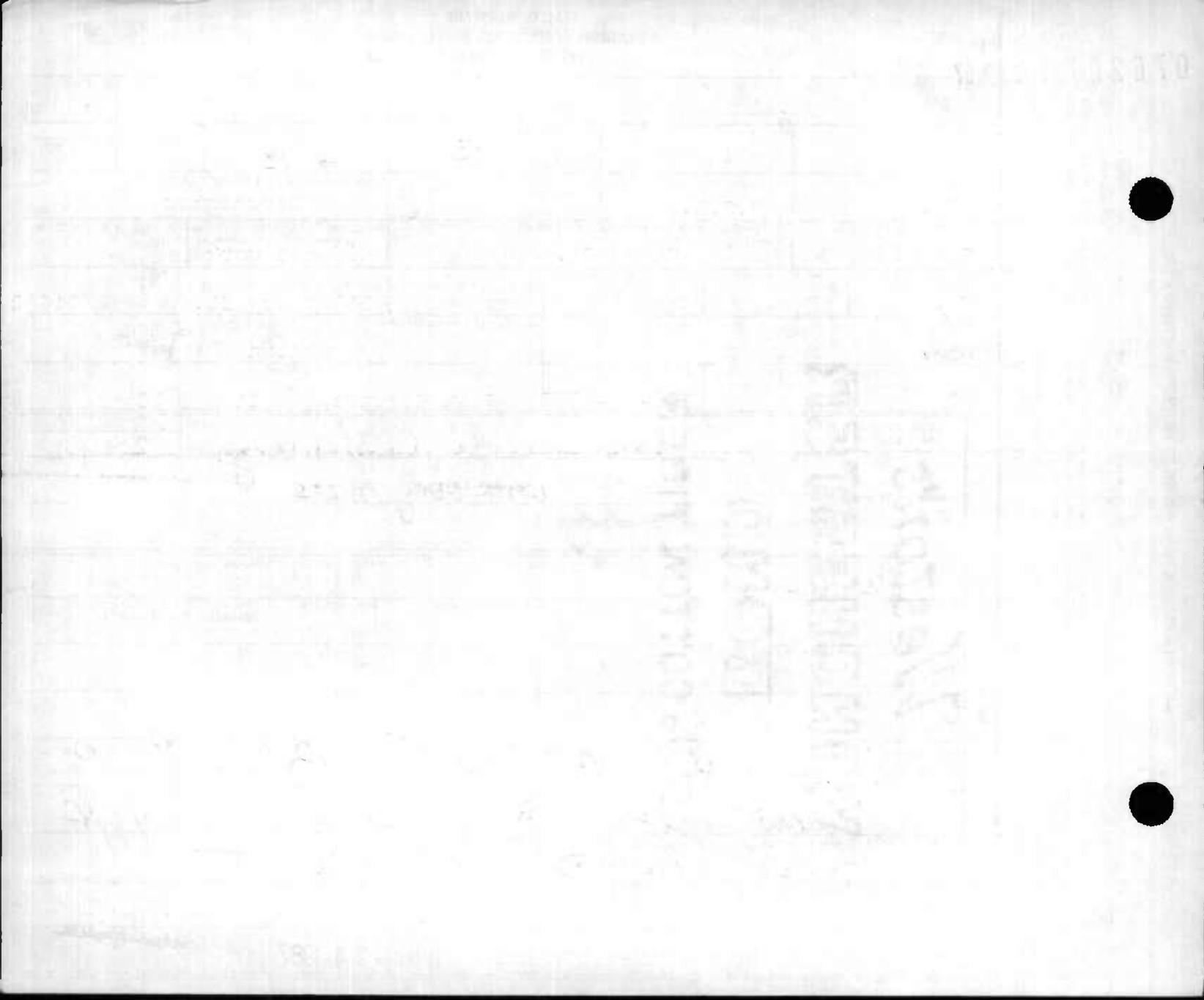
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 1 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified of one.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 35643			
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
1c DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	Dec. 16, 1987			11:00 pm		
Maybelle			Moore						
3. SEX Female	4 RACE white	5 DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1922	6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 73 yrs			7b CITIZEN OF WHAT COUNTRY? U.S.A.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD					
10. CITY OR TOWN OF DEATH Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 210 Henry St.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) did not work			12b KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.	13b. COUNTY Dor.	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 210 Henry St. 21613			
14. FATHER'S NAME FIRST unknown	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST unknown			16. SOCIAL SECURITY NO. 220-10-9555			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)			17. INFORMANT Jean Stewart Item # 13			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) Bronchogenic Ca of lung with bony mets APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)  Psychosis									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) 19/19/87							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (This hospital) attended the deceased from saw the deceased on 19/19/87, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We did) not view the body after death.									
22b. SIGNATURE Hubert L. Gibbons	22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12/16/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hubert L. Gibbons	22e. ADDRESS 503 BYPN ST								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial	23b. DATE 12/19/87	23c. NAME OF CEMETERY OR CREMATORIAL Green Lawn Cem.			23d. LOCATION CITY OR TOWN Cambridge, Dor. Md.			23e. COUNTY Md.	
24. FUNERAL DIRECTOR NAME THOMAS FUNERAL HOME	ADDRESS CAMBRIDGE MD.			25a. DATE REC'D. BY REGISTRAR DEC 24 1987			25b. REGISTRAR SIGNATURE		
BP _____									
DHMH - 16 60M 7/84 (VRA 15, 4)									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other trauma to the deceased, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												35644	
												REG. NO.	
DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR			
Sarah			L.		Morgan	12	1	87	87	6:45PM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HR			
Female		Black		MONTH DAY YEAR		80		MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Md.		U.S.A.				Dorchester Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY				
Cambridge			Cambridge House			Retired.							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE					
Maryland		Dorchester		Cambridge				934 Pine St / 21613					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Unknown						Unknown							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
(YES, NO OR UNKNOWN)			220-01-7134			Gray Chandler 934 Pine							
18 CAUSE OF DEATH (Enter only one cause per line for 1a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration & Respiratory Arrest												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
912 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/7 87, to 12/7 87, that (I) (we) last saw the deceased alive on 12/7 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Mary Ann Moore			MD										
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS										
Mary Ann Moore			404 BRENST, CAMBRIDGE, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			12/12/87			Christ Church Cemetery Cambridge			Dorchester Co. Maryland				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE RECEIVED BY DIRECTOR			25b. REGISTRAR'S SIGNATURE				
Stewart Funeral Home Cambridge Md.						12/08/87							

4918-34-316

POST TO LÖHNER

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon patient. Pages 1 through 3 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 81 355645
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Martha S</i>	MIDDLE <i>Perry</i>	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
3. SEX <i>Female</i>			4. RACE <i>Black</i>	5. DATE OF BIRTH MONTH <i>Mar</i> DAY <i>18</i> YEAR <i>1910</i>	6. AGE IN YEARS LAST BIRTHDAY MONTHS <i>77</i> YRS.	IF UNDER 1 YEAR MONTHS <i>0</i>	IF UNDER 24 HRS. HOURS <i>8</i>	IF UNDER 24 HRS. MIN. <i>PM</i>				
7a. BIRTHPLACE COUNTRY <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i>						
10. CITY OR TOWN OF DEATH <i>Cambridge</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester Gen Hospital</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>						
13a. STATE <i>Md.</i>		13b. COUNTY <i>Dorchester</i>		13c. CITY OR TOWN <i>Cambridge</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <i>709 Green Wood Ave / 21613</i>				
14. FATHER'S NAME FIRST <i>Palestine</i>			MIDDLE <i>Plate-</i>	LAST	15. MOTHER'S MAIDEN NAME FIRST <i>Martha</i>			MIDDLE	LAST <i>Dixon</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. <i>243-14-7935</i>			17. INFORMANT ADDRESS <i>Dr. Hale Perry 709 Greenwood Ave / 21613</i>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF Possible Cardiopneumonia or Septic												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Organic B. syndrome, Dehydration, D. Mellitus, Renal Failure</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>E. Tannan</i>		22c. DEGREE <i>MD</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>11-22-87</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tannan</i>		22e. ADDRESS <i>17 Franklin St. Cambridge, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>11/28/87</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>618 Field Lane</i>			23d. LOCATION CITY OR TOWN <i>Church Creek Dor</i>		COUNTY		STATE <i>Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Stewart Funeral Home Camb. Md.</i>		ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>DEC 03 1987 Julia Darden-Randall</i>							

DEC 03 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Then please remove carbon paper from back and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, have a medical examiner examine the deceased.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 35646			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	REG. NO.		
Donna Keyes Ruark						November 24, 1987				11:15 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR IF UNDER 24 HRS			
Female		White		Oct 28, 1947		40				MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		US				Dorchester Co.				MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY			
Cambridge		Rt 3 Box 140				Nurse							
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE					
Maryland		Dorchester		Cambridge		NO		Rt 3 Box 140		21613			
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
Sidney		Stokes	Keyes	Delia		Mae	Riley						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17. INFORMANT									
No		216-48-6112		James G. Ruark Item # 13									
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DIFFUSE ADENOCARCINOMA OF LUNG</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>PANCREATIC CARCINOMA</u> UNDET.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 8, 1987</u> to <u>Nov 24, 1987</u> , that (I) (last saw the deceased alive on <u>SEPT 24, 1987</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (did) <input type="checkbox"/> view the body after death.													
22b. SIGNATURE <u>Alfred R. Maryanov</u> DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <u>11/25/87</u>													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
Alfred R. Maryanov, M.D.		610 Race St., Cambridge, Maryland 21613											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN							
Burial		11/28/87		Seward Spedden Cem		Hudson Dor. Md.							
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE					
THOMAS FUNERAL HOME COLUMBIAN, MD.								NOV 30 1987		<u>Julie Gordon-Pendleton</u>			

## WINTER SEASIDE

**ATTENDING PHYSICIAN** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

110 HOSPITAL OF ATTENDING PHYSICIANS THE

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper from the back of page 3. Both sides of page 3 should be used within 72 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove entire paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified and informed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 3 5 6 4 8					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST John Lehman			MIDDLE Spear			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
John Lehman Spear												11 27 87				4:15 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M			CAUC			MONTH 12 DAY 02 YEAR 06			80 YRS			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. DATE OF BIRTH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
MD			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			DORCHESTER								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
CAMBRIDGE			DORCHESTER GEN			Foreman			Warehouse								
13a STATE			13b COUNTY			13c CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE					
MD			DORCHESTER			Secretary						South Street/21664					
14. FATHER'S NAME			15. MOTHER'S M AIDEN NAME			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
FIRST George			MIDDLE W.			LAST Spear			No -			221-01-7255			Robert E. Spear, Newark, DE 19713		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROSTATIC CA WITH PULMONARY METASTASES												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs					
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ANEMIA, DEHYDRATION, MILD RENAL FAILURE																	
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a I certify that (1) this hospital attended the deceased from 11/25/87 to 1987, that (2) I last saw the deceased alive on 11/26/87, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I did not view the body after death.)																	
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS			22e DATE SIGNED 11/27/87					
Hubert L. Fiery									503 BYRN ST								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY)			23b DATE			23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN			COUNTRY					
Burial			11-29-87			Unity Washington Cem. Hurlock, Dorchester, MD											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a DATE REC'D. BY REGISTRAR			25b REGISTRAR'S SIGNATURE								
Zeller Funeral Home, East New Market, MD 21631						DEC 13 1987			Julia Dawson-Landace								
BP																	
DHMH - 16 60M 7/84 (VRA 15, 4)																	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 35649			
1 - FOR STATE REGISTRAR			DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			Elsie Elizabeth Stack						December 20, 1987					8:00 AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		Month Day Year			87		MONTHS DAYS		HOURS MIN				
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Delaware		US		June 25, 1900			Dorchester Co. MD								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Cambridge		411 Cedar Street			Homemaker										
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e STREET ADDRESS / ZIP CODE			
13a STATE		13b COUNTY		13c CITY OR TOWN			13d INSIDE CITY LIMITS?		411 Cedar St. 21613						
Maryland		Dorchester		Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
14 FATHER'S NAME		FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME			ADDRESS								
Casper		Porter		Annie			P.O. Box 622								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT			PART I DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No		220-28-0231		Gloria Braughler			Muocardial Infarction		IMMEDIATE						
IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF			PART II										
(b) Atherosclerosis		DUE TO, OR AS A CONSEQUENCE OF						4 years							
(c) Hypertension		DUE TO, OR AS A CONSEQUENCE OF						years							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. —————— 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NON WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (this hospital) attended the deceased from 7/1/1980 to 12/20/1987, thos (we) lost															
saw the deceased alive on 12-14 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (we) did not view the body after death.															
22b SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED				
Michael A. Moskowicz		MD									12-21-87				
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS													
Michael A. Moskowicz		503 Bryan St. Cambridge MD.													
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN		COUNTY		STATE				
Burial		12/22/87		Unity Wash Cem			Hurlock Dor. Md.								
24 FUNERAL DIRECTOR		ADDRESS			25a DATE REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE								
THOMAS FUNERAL HOME CAMBRIDGE, MD.					DEC 24 1987										

16630 48835

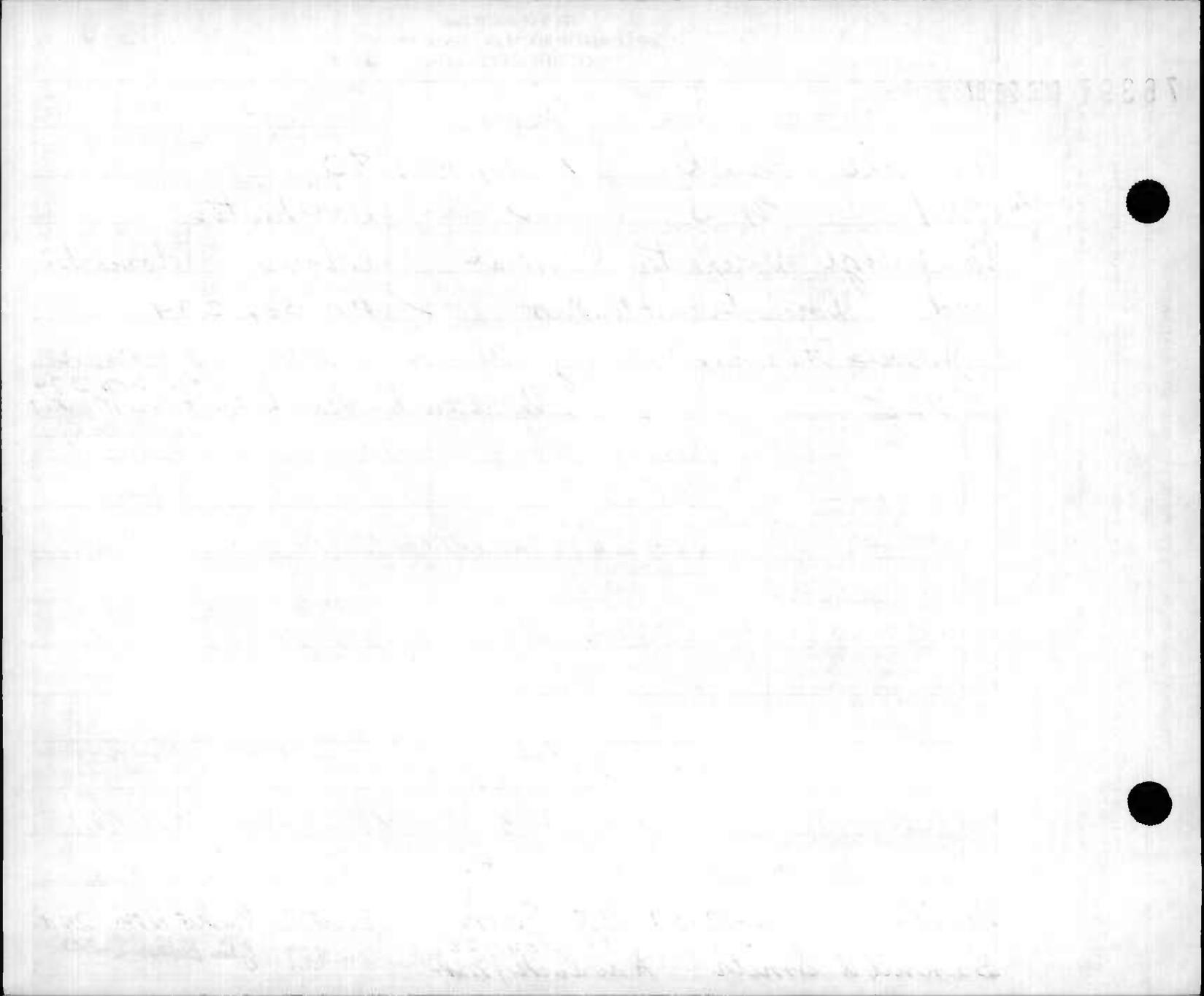
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the burial permit. Then please remove carbon paper. Pages 1 and 2 may be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
REG. NO. 87 35650																	
1 - STATE REGISTRAR			1a DECEASED NAME (TYPE OR PRINT)			1b FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR								
Hattie Mae Stanley						12 18 87			2b HOUR 11:35 M								
3 SEX Female		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YEAR MONTHS DAYS			# UNDER 24 HRS HOURS MIN.						
7a BIRTHPLACE COUNTRY Md.		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Dorchester MD.		10a CITY OR TOWN OF DEATH Cambridge			11a NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Dorchester General						
12a USUAL OCCUPATION Laborer			13a KIND OF BUSINESS OR INDUSTRY domestic			13b STATE OR FOREIGN Md.			13c COUNTY Dorchester East New Market			14a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13d STREET ADDRESS / ZIP CODE P.O. Box 27421631		
14b MOTHER'S MAIDEN NAME alma Mae Jackson			14c ADDRESS P.O. Box 274			15a FATHER'S NAME James Herman Conway			15b SOCIAL SECURITY NO. No.			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (If Yes, Give War or Dates)			16b INFORMANT Andrew Deshields East New Market		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MULTIPLE ORGAN FAILURE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS																	
DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS DAYS																	
DUE TO, OR AS A CONSEQUENCE OF (c) SMALL BOWEL PERFORATION DAYS																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a LOWER G.I. HEMORRHAGE																	
19a DATE OF OPERATION 12/3/87 12/8/87			19b CONDITION FOR WHICH OPERATION WAS PERFORMED 12/3/87 by hemorrhage 14/8/87 Performed several hrs			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)											
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE											
22a I certify that (1) this hospital attended the deceased from 12/4/87 19 87 to 12/18 19 87 that (1) (we) last saw the deceased alive on 12/18 19 87 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (I) (did) (did not) view the body after death.																	
22b SIGNATURE David B. Stoeckle			22c DEGREE MD			22d ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e DATE SIGNED 12/18/87								
23a PHYSICIAN'S NAME (TYPE OR PRINT) DAVID B. STOECKLE MD.			23b ADDRESS 800 MARYLAND AVE CAMBRIDGE, MD 21613			23d LOCATION CITY OR TOWN East New Market Dor. 2nd.											
23e BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23f DATE 12-23-87			23g NAME OF CEMETERY OR CREMATORIAL Mt. Zion			23h LOCATION CITY OR TOWN East New Market Dor. 2nd.								
24 FUNERAL DIRECTOR NAME Bennie L. Smith			24 ADDRESS P.O. Box 928 7 Mullock, MD			25a DATE REC'D. BY REGISTRAR DEC 28 1987			25b REGISTRAR'S SIGNATURE Julia Gordon-Burke								



075256 DEC 16 87

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove all blue ink from pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										87 35651				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
Jane R Stringfield						12 10 87						8PM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female			Caucasian			March 9, 1908			79			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania			U.S.A						Dorchester					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Cambridge House			Teacher								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
Md.			Dor.			Cambridge						520 Glenburn Ave. 21613		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST					
Octavus			P.	Large	Emma						Magill			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			178-32-8089			Octavus P. Large Jr. Oxford MD 21654			P.O. Box 315					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														
(b) DUE TO, OR AS A CONSEQUENCE OF Possible myocardial infarction														
(c) DUE TO, OR AS A CONSEQUENCE OF ASCV														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Chronic Schizophrenia														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			22c. DATE SIGNED								
<i>E. Tanman</i>			MD			12-10-87								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS								
E. Tanman						17 Franklin St. Cambridge MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
cremation			12/11/87			Salisbury Crematory			Salisbury			Wic.	Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
<i>Thomas Funeral Home</i>						DEC 15 1987			<i>Julia Johnson-Bailey</i>					

Serial 221310

DEC 12 1981 (See Remarks)

TO HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached from the back of the form and mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner will be called in to examine the body.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 87 35652			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST JAMES MOLTON TALL James H. Tall			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
MALE		CAUC.		12-22-1916			70 YRS.								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER			MD.					
MARYLAND		U.S.A.													
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DORCHESTER GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) WHOLESALE SEAH SHELLFISH			12b. KIND OF BUSINESS OR INDUSTRY								
12. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY DORCHESTER		13c. CITY OR TOWN FISHINGCREEK			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE GENERAL DELIVERY, 21634					
14. FATHER'S NAME FIRST JOHN MIDDLE LEANDER LAST TALL		15. MOTHER'S MAIDEN NAME FIRST UNK. MIDDLE P. LAST PRITCHETT													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-09-1518		17. INFORMANT MRS. NAOMI TALL, SAME AS #13			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years								
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>CARCINOMA COLON, METASTATIC</i></p> <p>DOUE TO, OR AS A CONSEQUENCE OF (b) _____</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>DOUE TO, OR AS A CONSEQUENCE OF (c) _____</p> <p>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a</p>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input type="checkbox"/> (I) this hospital attended the deceased from <i>12/17/87</i> to <i>12/17/87</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) we (did) (did not) view the body after death.															
22b. SIGNATURE <i>Craig W. Adcock</i>		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <i>12/18/87</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Craig W. Adcock</i>		22e. ADDRESS <i>DORCHESTER GENERAL HOSPITAL, CAMBRIDGE MD.</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-20-1987			23c. NAME OF CEMETERY OR CREMATORIAL DORCHESTER MEM. PK			23d. LOCATION CITY OR TOWN CAMBRIDGE, DORCHESTER, MD.							
24. FUNERAL DIRECTOR NAME 308 HIGH ST, CAMBRIDGE, MD. 21613		25a. DATE REC'D. BY REGISTRAR JULY 21 1987			25b. REGISTRAR'S SIGNATURE <i>Julie Sander-Randall</i>										

02265303

MAP 8180

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

37 35653

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
<i>Ellen</i>			<i>m</i>	<i>Thompson</i>		<i>11-20-87</i>				<i>9:20 A.M.</i>	
3 SEX	4 RACE	5 DATE OF BIRTH	MONTH	DAY	YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	# UNDER 24 HRS	2b HOUR		
<i>F</i>	<i>W</i>	<i>4 3 17</i>	<i>70</i>			MONTHS	MONTHS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH				
<i>Maryland</i>	<i>USA</i>						<i>Dorchester</i>				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
<i>Cambridge</i>	<i>Dorchester General Hospital</i>					<i>Housewife</i>					
13a STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE			12b KIND OF BUSINESS OR INDUSTRY		
<i>Maryland</i>	<i>Dorchester</i>	<i>Madison</i>				<i>Rt 4 Box 1</i>			<i>Home</i>		
14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
<i>John</i>	<i>ard</i>	<i>D</i>	<i>Reeley</i>	<i>Bessie</i>			<i>Ella</i>			<i>Wheeler</i>	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>NO</i>	<i>N/A</i>		<i>Betty Miller</i>			<i>Rt 4 Box 1 Madison MD 21468</i>			<i>Minister</i>		
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>											
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe Congestive Heart Failure</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus, Severe Chronic Obstructive Pulmonary Disease</i>											
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a I certify that (I) (this hospital) attended the deceased from <i>11/20</i> , 19 <i>87</i> , to <i>11/20</i> , 19 <i>87</i> , that (I) (we) last saw the deceased <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do) (do not) view the body after death.											
22b SIGNATURE <i>Reeley</i>											
22c DEGREE											
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>											
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edmund J. MacLaughlin</i>											
22e ADDRESS <i>10 Aurora St. Cambridge, Md 21613</i>											
23a BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE <i>11/24/87</i>	23c NAME OF CEMETERY OR CREMATORIAL <i>Ivy Hill Cemetery</i>			23d LOCATION CITY OR TOWN <i>Laurel</i>	CITY OR TOWN		COUNTY		STATE	
24 FUNERAL DIRECTOR <i>Fleck Funeral Home Inc.</i>	ADDRESS <i>7601 Sandy Spring Rd Laurel MD 20707</i>			25a DATE REC'D. BY REGISTRAR <i>NOV 27 1987</i>	25b REGISTRAR'S SIGNATURE <i>David Pendleton</i>						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

FOR  
STATE  
REGISTRAR

073521 DEC 1 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

87 35554

I. DECEASED NAME (TYPE OR PRINT)			FIRST <u>GEORGE</u>	MIDDLE <u>Milton</u>	LAST <u>TYLER</u>	2a. DATE OF DEATH MONTH YEAR	NOVEMBER 26, 1987	2b. HOUR 10:26 AM	
3. SEX Male		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 14, 1918			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS 69 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mariner			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Dorchester	13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 507 Goldsborough Ave 21613			
14. FATHER'S NAME FIRST George		MIDDLE Perry	LAST Tyler	15. MOTHER'S MAIDEN NAME FIRST Rita		MIDDLE	LAST Wright		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-10-3421			17. INFORMANT Bonnie Lyons 108 Maple Ave 21613		ADDRESS Cambridge, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Left Ventricular Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Recent Myocardial Infarction							
		DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 11/26/87, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									22c. DATE SIGNED 11/26/87
22b. SIGNATURE <u>Mary Ann D. Moore MD</u>		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS 404 BYRN ST., CAMBRIDGE, MD 21613				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/28/87		23c. NAME OF CEMETERY OR CREMATORIAL Dor Mem Park			23d. LOCATION CITY OR TOWN Cambridge Dor		
24. FUNERAL DIRECTOR THOMAS FUNERAL HOME CAMBRIDGE, MD.		ADDRESS THOMAS FUNERAL HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR NOV 30 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Lundeen		

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DHMH - 16 60M 7/84  
(VRA 15, 4)

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH8735655  
REG. NO.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH87 35656  
REG. NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

repaired by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event all medical records must be submitted to the State Dept. of Health and Mental Hygiene

1. DECEASED NAME (TYPE OR PRINT)			DELTA MAE	LAST WILLEY	2d. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
3. SEX			FEMALE	RACE	W I	5. DATE OF BIRTH	MONTH	DAY	YEAR			
6d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			Md.	7b. CITIZEN OF WHAT COUNTRY?	U.S	MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH			Cambridge	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			MD	13b. COUNTY			13c. CITY OR TOWN			SEAMSTRESS	FACTORY	
14. FATHER'S NAME			Friedrich Nehn	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			13e. STREET ADDRESS / ZIP CODE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			NO	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			-	213-09-8567			CHARLOTTE HUNTEMAN, CAMBRIDGE, MD 21613			2 months		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malignant glioma - left frontal parietal lobe</u>												
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>9/17/87</u> , 19 <u>87</u> , to <u>11/8/87</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>11/7/87</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Lawrence Maryanov</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>12/8/87</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <u>610 Race St</u> <u>Cambridge, MD 21613</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-10-87		23c. NAME OF CEMETERY OR CREMATORIAL ST. PAUL'S CEMETERY			23d. LOCATION CITY OR TOWN VIENNA, DORCHESTER, MARYLAND		23e. COUNTY		STATE	
24. FUNERAL DIRECTOR ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631		25a. DATE REC'D. BY REGISTRAR JAN 4 1988			25b. REGISTRAR'S SIGNATURE <u>John Zeller</u>							
BP												
DHMH - 16 60M 7/84 (VRA 15, 4)												

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the attending physician and will be filed by the medical examiner within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and retained by the hospital or attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows ANY injury, or other traumatic event, the medical examiner must be notified immediately.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
REG. NO. 87 35657													
1 - FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
SALLY J. WINN			12 13 87			4:45 PM							
3. SEX F		4. RACE NEGRO		5. DATE OF BIRTH MONTH 5 DAY 20 YEAR 91			6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH DORCHESTER MD						
10. CITY OR TOWN OF DEATH CAMBRIDGE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CAMBRIDGE HOSP		12a. USUAL OCCUPATION Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Md.		13b. COUNTY DORCHESTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 512 Pine St. 21613						
14. FATHER'S NAME William		LAST Nichols		15. MOTHER'S MAIDEN NAME Jessie Green									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? no		16b. SOCIAL SECURITY NO. 215-74-17		17. INFORMANT Agatha Chester Cambridge Md			ADDRESS 512 Pine St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) Yes													
DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. Atrial fibr. s/p CVA Advanced age													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____								
22a. I certify that (I) (this hospital) attended the deceased from 12/17/85 to 12/13/87, that (I) (we) last saw the deceased alive on 12/13/87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.													
22b. SIGNATURE HUBERT L. PERRY MD		22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 12/13/87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT L. PERRY MD		22e. ADDRESS 503 BYRN ST											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-87		23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION CITY OR TOWN CAMBRIDGE COUNTY DORCHESTER STATE MD						
24. FUNERAL DIRECTOR NAME BENNY SMITH		ADDRESS P.O. Box 928 HARBOR, MD.			25a. DATE REC'D. BY REGISTRAR DEC 28 1987			25b. REGISTRAR'S SIGNATURE BENNY SMITH					
DHMH - 16 60M 7/84 (VRA 15. 4)													

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